

The Relation between Lichen Planus and Hepatitis C: A Case Report

TOVE AGNER¹, HANNE FOGH² and KAARE WEISMANN¹

Department of Dermatology, ¹Bispebjerg Hospital and ²Rigshospitalet, Copenhagen, Denmark

A case of simultaneous occurrence of lichen planus (LP) and hepatitis C in the same patient is presented. The patient had received treatment with interferon alpha for her chronic liver disease, and the association between LP, hepatitis C and interferon alpha treatment is discussed.

(Accepted March 16, 1992.)

Acta Derm Venereol (Stockh) 1992; 72: 380.

Tove Agner, Department of Dermatology, Bispebjerg Hospital, DK-2400 Copenhagen NV, Denmark.

An association between lichen planus (LP) and chronic active hepatitis (1), as well as between LP and primary biliary cirrhosis, has been described (2), although one study was not able to confirm an association between oral LP and chronic active hepatitis (3). The association between LP and liver disease was sustained in a recent multi-centre study including 577 patients with LP (4). Recently, the simultaneous occurrence of LP and hepatitis C in one patient was reported (5). An additional case is reported here.

CASE REPORT

A 53-year-old woman with chronic active hepatitis since 1983 was referred as an outpatient to our dermatological clinic because of a persisting itch. She had a history of deep venous thrombosis of the legs and lung emboli, and had received antithrombotic treatment, and she also had a history of upper gastrointestinal bleeding. In 1990, she was recognized as anti-HCV-positive and she was treated with interferon alpha from June 1990 to June 1991. No significant changes in liver enzymes were found in relation to the interferon alpha therapy, or in relation to the eruption of LP. Skin symptoms commenced in May 1991 after 10–11 months of treatment with interferon. Brown/violaceous papules were symmetrically located on her trunk and extremities, notably on her hands and feet. No mucosal involvement was found. The diagnosis of LP was confirmed histopathologically from a skin biopsy. The results of laboratory studies in July 1991 were as follows: HBs antigen negative, anti-HBs negative, anti-HCV-positive (test method Elisa 100 and RIBA 4, Ortho), aspartate aminotransferase (ASAT) 134 U/l, IgG 137 µl, IgM 1.1 µl, IgA 9.9 µl. Liver biopsy specimen from August 1991 showed chronic aggressive viral hepatitis with active cirrhosis.

Because of intensive itching, therapy for LP was needed. Local application of potent steroids did not improve the skin symptoms. PUVA treatment was then attempted under close control of the ASAT values. After 5 weeks of PUVA treatment (3 times weekly) the skin lesions and itch cleared, while ASAT values remained unchanged.

DISCUSSION

To our knowledge, this is the second reported case of LP and hepatitis C occurring in the same patient. A possible relation

between these two diseases would partly explain the increased risk of LP in patients with a history of liver disease (4) and would also lead to new considerations about the etiology of LP. It has been reported that treatment with D-penicillamine in patients with primary biliary cirrhosis may lead to development of LP (6). In our patient, an association between the treatment with interferon alpha and the appearance of the skin lesions is a possibility. Recently, a case of LP induced by interferon alpha in a patient with IgG myeloma was presented (7). In that case the skin lesions appeared after 6 weeks of treatment with interferon alpha. Our patient had received treatment with interferon alpha for 11 months before she developed LP. Moreover, LP lesions were not localized to or accentuated at the sites of injection. Our present findings should, however, be seen in the perspective of the prevalence of LP in interferon-treated patients with hepatitis C. In a recent study, 22 patients with hepatitis C were followed for 36 weeks. Fifteen of these received treatment with interferon alpha (8). No case of LP was reported. In another study, 126 patients with hepatitis C, 91 of which received interferon alpha treatment, were followed for 24 weeks, and no case of LP was reported here either (9). More reports and studies are necessary to come to a conclusion about an association between LP, hepatitis C and interferon alpha treatment.

REFERENCES

1. Rebora A, Rongioletti F. Lichen planus and chronic active hepatitis. *Acta Derm Venereol (Stockh)* 1984; 64: 52–56.
2. Graham-Brown RAC, Sarkany I, Sherlock S. Lichen planus and primary biliary cirrhosis. *Br J Dermatol* 1982; 106: 699–703.
3. Mobacken H, Nilsson LÅ, Olsson R, Sloberg K. Incidence of liver disease in chronic lichen planus of the mouth. *Acta Derm Venereol (Stockh)* 1984; 64: 70–73.
4. Gruppo Italiano Study Epidemiologici in Dermatologica. Lichen planus and liver disease: A multi-centre case-control study. *Br Med J* 1990; 300: 227–230.
5. Mokni M, Rybojad M, Puppini D, Catala S, Venezia F, Djian R, Morel P. Lichen planus and hepatitis C virus. *J Am Acad Dermatol* 1991; 24: 792.
6. Weismann K, Wantzin GL, Christensen E. Lichen planus ved penicillamin-behandlet primær bilier cirrhose. *Ugeskr Læger* 1986; 48: 456–457.
7. Rodrigues B, Oliveira M, Inock A. Lichen planus induced by interferon alpha-2b in a patient with IgG myeloma. *Nouv Dermatol* 1989; 8: 29–31.
8. Schwarz R, Weiland O, Wejstål R, Norkrans G, Frydén A, Foberg U. A randomized controlled open study of interferon alpha-2b treatment of chronic non-A, non-B posttransfusion hepatitis: no correlation of outcome to presence of hepatitis C virus antibodies. *Scand J Infect Dis* 1989; 21: 617–625.
9. Davis GL et al. Treatment of chronic hepatitis C with recombinant interferon alfa. A multicenter randomized, controlled trial. *N Engl J Med* 1989; 321: 1501–1506.